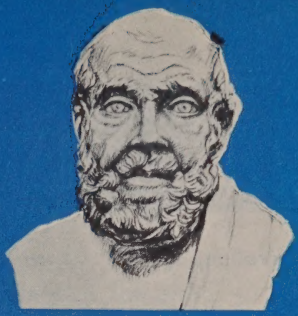
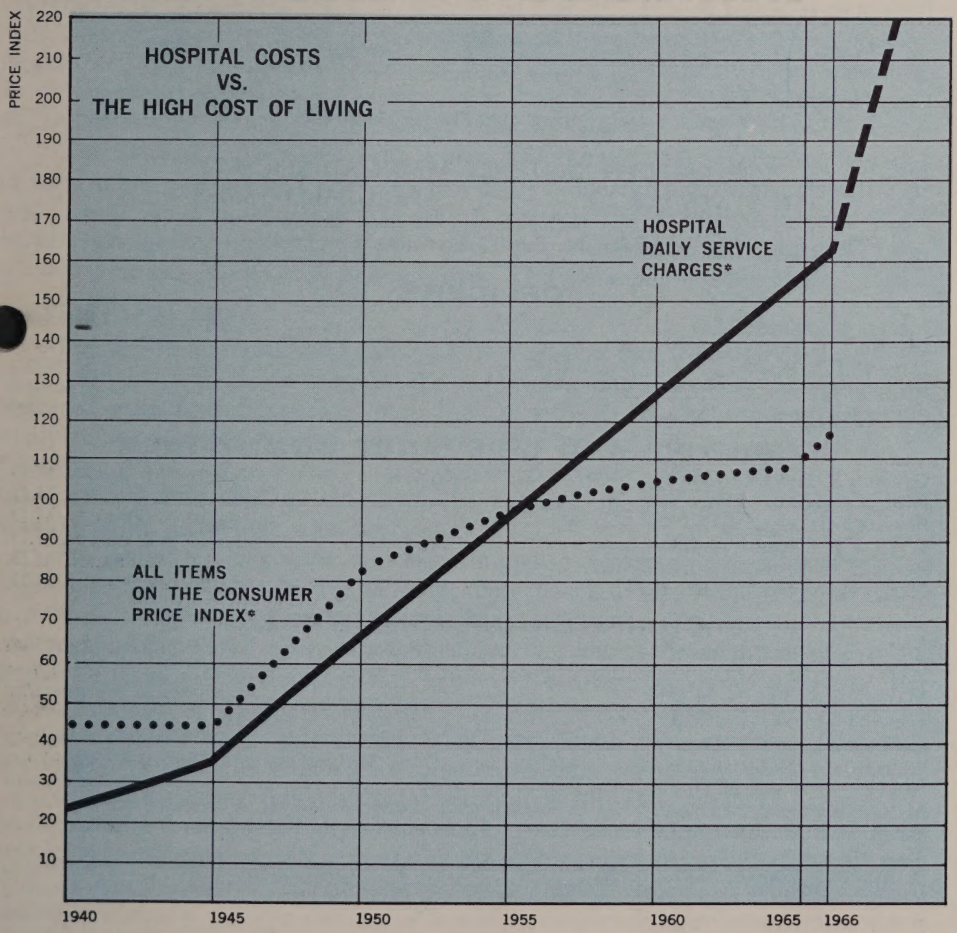
The Hampden Hippocrat



A CRITICAL PROBLEM...



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Health Care Costs

"The question is not whether medical prices will rise in the future, but how fast." Such is the statement contained in a study ordered by President Johnson and released by the Dept. of Health, Education, and Welfare last spring. The report's statistics show that for the year December 1965 to December 1966 the Consumer Price Index rose 3.3%, but the cost of medical care went up 6.6%. Daily hospital charges increased 16.5%, five times the rise in the consumer price index. In comparison are the average annual increases for 1960 through 1965; consumer price index, up 1.3%; all medical care, up 2.5%; hospital daily charges, up 6.3%.

A recent release by the U.S. Bureau of Labor Statistics stated that health care costs increased by 6.7% during the first six months of 1967. The increase, as reported by the Bureau's Consumer Price Index, included increases of 6.8% in physicians' fees and a 19.1% increase in hospital daily service prices; whereas, the total cost of living rose 2.6% during this period.

The Bureau's Consumer Price Index also showed that physicians' fees increased 35% and hospital daily service charges increased 85% between 1955 and 1965. As a comparison, the C.P.I. showed the following increases for certain goods and services for the same period: tobacco products, 30.5%; alcoholic beverages, 10.3%; personal care, 22%; reading and recreation, 25%.

PHYSICIANS' FEES

Despite some vociferous denunciations against the "relentless escalation" in physicians' fees, is such really the case when one considers the matter in terms of relativity? Physicians' fees, if they seem to be rising today, reflect a readjustment dictated by our inflationary economy, by society's insistence on a relatively stable fee schedule based on the procedure performed rather than on a sliding scale of fees based on the patients' income, and by the classic economic law of supply and demand.

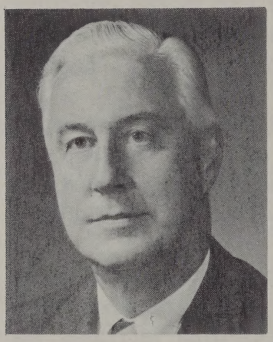
For a variety of reasons, which we intend to explore in some depth on the following pages, many factors but especially hospital costs appear to be contributing to the ever increasing spiral of health care costs. Charges and countercharges, some justified and some unjustified, are being leveled by those in the health services industry on the one hand and by their critics on the other. In between stands the physician, who not only is a "vendor" of health care services but also the patient's "purchasing agent" for health care services. As such, it is the physician who is going to be seriously affected by this conflict.

Change in the traditional organization of health care practices appears to be inevitable. It is for us physicians not only to become expertly knowledgeable and sophisticated concerning the socioeconomics of health care in the light of rapid and far reaching technological and sociological evolutions but also to insistently assume our rightful role as responsible leaders guiding this change toward one goal—the best health care possible at the right time, the right place and the right price to as many as possible.

John C. Ayres, M.D.

President's Page

Self Help



One of the facets in the maintenance of health may become obscured in the light of medical progress. Active participation by the individual is an essential component of health.

With emphasis given to medical care and so little to health education and individual responsibility for personal health, there is a misconception on the part of the public that a quick solution to health problems can be purchased.

Indulging in excessive physical and emotional insults to the body and expecting the doctor to be the "healer" of all ills is not the solution to health.

Health demands active participation. It cannot be given or bought.

We as physicians must encourage our patients to cooperate in their illnesses. We have the responsibility of teaching health as well as healing.

Self-discipline of food habits, smoking and drinking excesses must be a personal responsibility. There is no quick solution when the body rebels.

Much of man's personal health must be earned.

Joseph M. Baker M.D.

Joseph M. Baker, M.D.

COVER: A chart developed from the U.S. Bureau of Labor Statistics' Consumer Price Index based upon a 1957-59 index of 100.

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The Rising Cost of Hospitalization

Inevitably, the medical profession is being held accountable for the ever mounting cost of medical care. The purpose of this writing is threefold: 1) to attempt to clarify the underlying factors involved; 2) what attempts have been made and those under way to resolve this ever increasing rise of hospital care; 3) as physicians, what are our responsibilities and how can we help.

RISING HOSPITAL COSTS

Reported statistics show that in the period from 1960 through 1965, Consumer Price Index rose 1.3%; medical care was up 2.5% while hospital daily charges increased 6.3%. For the single year December 1965 to December 1966, the Consumer Price Index rose 3.3%; medical care went up 6.6%; but daily hospital charges increased to 16.5%, fivefold the rise of the Consumer Price Index.

A combination of unique influences has caused the steep rise in the hospital's cost problems. In no way is blame directed to the hospital administrator but to the interplay of many complex situations, including Congress and the American people.

Advances in medical science have radically changed the very complexion of hospital operation. The hospitals have had to acquire expensive medical equipment and, by necessity, have had to hire more skilled employees. In industry, automation and mechanization have brought about substantial increases in productivity in terms of per man-hours. In contrast, the hospital, by its very operation is limited and cannot entirely automate personal services. Hospitals do not manufacture a product. They perform a service which cannot be defined within a computer.

The magnitude of the labor cost factor is, perhaps, the single most important element of the problems which beset our hospitals. In a hospital, one out of three employees is a skilled individual compared, to say the automobile industry, where the ratio is one out of six. In 1946, the hospital average short term patient required 1½ employees per patient. Today, the ratio is closer to three and undoubtedly will rise further.

An even greater impact for the spiralling cost of hospital care is the steep rise of employees' wage rates. The hospitals, by necessity, have had to upgrade their pay scales to maintain and keep their skilled employees and professional staff, but even today they still lag behind industry's rates.

The problem of the cost rise of hospital care and its solvency is bewildering. One hospital administrator in Rhode Island replied, when asked for a solution: "I haven't the faintest idea." He predicted that per diem costs would reach $100.00 by 1970. An administrator from Ohio has rendered the impression that the American people have little, if any, knowledge or the desire to learn about and understand these problems. Is there a solution to the rise of hospital costs?

Throughout our country, most hospital administrators and physicians alike, are seriously implementing every known knowledge to the ever mounting cost of hospitalization and medical care. To succeed at all, the solution requires the cooperation of the hospital administrator, the physician and the governing board of each hospital. Most important of all, is the education of Congress and the American people.

Hospital administrators have employed fiscal controls, budgeting, and electronic data processing equipment. Attempts have been made in the area of personnel productivity, in upgrading technician task, and improving utilization. The areas of pool purchasing, the

use of disposables, inventory controls, and cost finding procedures in cost-price ratios have been upgraded.

The following examples by various hospital administrators show their earnestness and serious concern. One administrator cut the laundry costs to $50,000 a year and food costs by $100,000 a year without altering the quality, by obtaining the aid of an industrial engineer. A Cincinnati, Ohio, administrator states "piping oxygen saves us 39% per 100 cubic feet and our management improvements have reduced by 25% positions at this level." Another hospital administrator has saved as much as $60,000 through joint purchasing.

Some hospitals have formed joint corporations to operate central services or joint programs. The hospitals have not surrendered their autonomy.

Comparative studies are under way which show that "patients admitted on Friday and Saturday remain two days longer than the lowest average stay". The lack of ancillary facilities on Saturday and Sunday is a direct contributory factor. It is the opinion of some of our leading hospital administrators that a 7 day work week for their ancillary services would shorten the stay of some patients, increase the admission rate, and save patients money. One report from a medium sized hospital showed the estimated saving to patients in one year was close to half a million dollars, by the employment of a 7 day work week.

WHAT CAN PHYSICIANS DO?

At the 1966 Clinical Convention of the A.M.A., the House of Delegates urged every physician to develop an awareness of the economic consequences of treatments prescribed for their patients. They further stated that "excellence of the hospital management is not solely the responsibility of the governing authority and administrator. The medical staff is responsible for much of the hospital income and expense. Therefore, through its officers and committees and chiefs of departments, the medical staff must be concerned with and share responsibility for the quality and efficiency of the total management of the hospital".

The physicians, through their utilization committees, can shorten hospitalization stays, avoid unnecessary admissions, and more carefully select laboratory procedures necessary for the diagnosis of the patient's ailment.

PUBLIC EDUCATION

The professionals are doing everything possible to help combat the rise of hospital costs. This, however, is inadequate. Congress and the American people must be more aware of the acute situation. It is professionals who will read this article, the very ones who understand it. Is it not more profitable that we communicate with the people? The word "education" is derived from the Latin "educare" which means to "lead out" or "lead forth". It is the responsibility of every physician, hospital administrator, nurse and member of a hospital governing board, as well as our medical societies, to educate and to bring to our community the core of the problem. Unless these steps are taken, the phenomenal rise of hospital costs pose a threat to our voluntary health system.

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NEXT MEETING OF THE HAMPDEN DISTRICT MEDICAL SOCIETY

TIME: TUESDAY, DECEMBER 5, 1967
Business meeting at 6:00 p.m. followed by Social Hour at 7 p.m. and
* Dinner (Courtesy of Society) at 7:30 p.m.

PLACE: STORROWTON TAVERN, STAGE-COACH BARN
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PROGRAM: Donald A. Nickerson, M.D., President
Massachusetts Medical Society

YOUR PRESENCE IS URGENTLY REQUESTED

John F. Griffin M.D.

JOHN F. GRIFFIN, M.D., *Secretary*

* If you find you must cancel your dinner reservation, please do so before 12 noon on December 5, 1967.

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For brief summary of prescribing information, see reverse side.

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Indications: "Symmetrel" is indicated for the prevention (prophylaxis) of influenza A_2 in persons of all age groups. Early use is recommended, preferably before or as soon as possible after actual or suspected contact with individuals suffering from influenza A_2. "Symmetrel" should especially be considered for high influenza-risk patient groups such as those suffering from chronic debilitating diseases and elderly persons.

Contraindications: Not indicated for the prevention of influenza or respiratory disease other than influenza A_2 or for the treatment of established illness. Availability of "Symmetrel" should not affect the physician's usual vaccine practices.

Warnings: Administration to patients with central nervous system disease, particularly geriatric patients with cerebral arteriosclerosis, and patients with a history of epilepsy or other "seizures", requires strict observation for possible untoward effects (see Adverse Reactions). Patients taking psychopharmacologic drugs, central nervous system stimulants, or alcoholic beverages should be observed for possible evidence of intolerance. Those patients who experience central nervous system effects or blurring of vision should be cautioned against driving or working in situations where alertness is important.

No teratogenic effects have been seen in reproductive studies in rats and rabbits. Studies in pregnant women have, however, not been done and use of this drug in women of childbearing age should be undertaken only after weighing the possible risks to the fetus against benefit to the pregnant patient. It should not be administered to nursing mothers since it is not known whether the drug is secreted in the milk.

Precautions: Ineffective against bacterial infections. Patients should be observed for idiosyncratic reactions as with all new drugs. Geriatric patients with pre-existing serious medical illnesses with mental or physical deterioration should be followed carefully while taking "Symmetrel". (See Adverse Reactions.)

Adverse Reactions: With higher than indicated doses manifestations of central nervous system effects such as nervousness, insomnia, dizziness, lightheadedness, drunken feeling, slurred speech, ataxia, inability to concentrate and some psychic reactions including depression and feelings of detachment were seen. Occasional blurred vision was reported at higher doses. Some of the milder and less pronounced symptoms above have been reported in a small number of patients taking the recommended dosage of 200 mg per day. These were mostly transient and disappeared with continued administration of the drug. Some geriatric patients developed paranoid or hallucinatory behavior and became unmanageable while taking 200 mg daily. Medically unselected seriously deteriorated geriatric patients showed poor clinical tolerance after several weeks of daily dosing with 200 mg per day. One elderly patient with a history of prior cerebrovascular accident developed visual hallucinations and grand-mal convulsions while on the drug at 800 mg per day. Some cases of dry mouth, gastrointestinal upset and skin rash and, rarely, tremors, anorexia, pollakiuria, and nocturia have been also reported.

Dosage: Adults: Two 100 mg capsules (or 4 teaspoonfuls of syrup) as a single daily dose; or the daily dose may be divided into one capsule of 100 mg (or 2 teaspoonfuls of syrup) twice a day.

Children: 1 yr.—9 yrs. of age: Calculate total daily dose on the basis of 2 mg to 4 mg per pound of body weight per day (but not to exceed 150 mg per day). Daily dose, given as the syrup, should be given in 2 or 3 equal portions.

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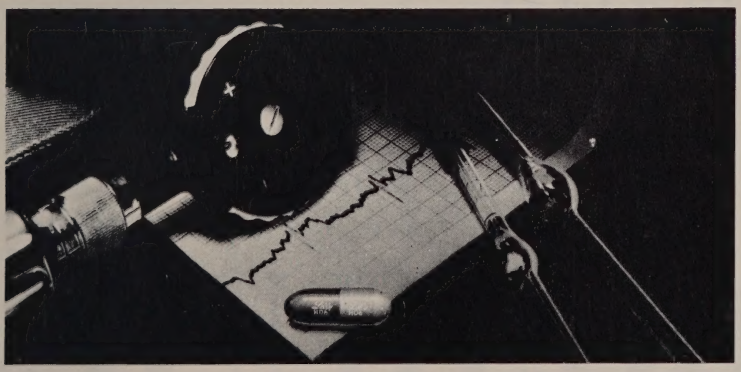
Some Whys and Wherefores of Health Care Costs

It is common knowledge that expenditures for health care services have been growing rapidly of late and that the share of total spending allocated to health care has also been rising. Changes in sector shares of the gross national product seem to be a natural accompaniment of economic growth, as witness the relative decline of agriculture and manufacturing as compared to rise in the service sector, particularly, that pertaining to health care. There is nothing basically wrong in this but queries rise as to whether there is a concomitant rise in levels of health or at least the most efficient utilization of resources being devoted to health care. Our economic system is based on the premise that hope of profit under conditions of open competition can assure efficiency with a suitable price, a befitting rate of output, and a fair return to production. Such does not seem to be the situation in the health care industry since it seems to be organized along different lines. Most hospital services are on the basis of nonprofit operation. There are various restrictions on entry and competition in health care service fields. There is increasingly more collective responsibility since a large and ever increasing portion of the expenditures for health services are being paid by third parties.



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DEMAND

Economists claim that the demand for any goods or service depends upon relative prices, income, and tastes. Insofar as demand for health care services is concerned, there seems to be a relative inelasticity where price is concerned since there doesn't seem to be a proportionate decrease in demand as the price goes up. Moreover, demand for health care services seems to increase to some degree in proportion to income. All other factors, usually called taste by economists, include such demographic variables as age, sex, race, etc.; education, environment; ways of living; and genetic stock. There is very little factual data available currently to determine the exact influence of taste factors on demand for health care services. Certainly population growth with a proportionally larger prevalence of those in the higher and lower age brackets increases the demand for health care services. Likewise, a more and better educated population might demand more health care services. However, by the same token, such a population group should also take greater advantage of prevention thereby neutralizing some of the demand. Or are we educating more and better neurotics?

SUPPLY

In analyzing supply, economists look at such factors as labor and capital flowing into the industry, changes in productivity, and marketing imperfections such as monopoly control that may influence the supply actually available to consumers. Employment in the health care service field has grown tremendously during the postwar period, and still there is a shortage of personnel. Moreover, wages for personnel have been and are increasing at a relatively higher pace within the

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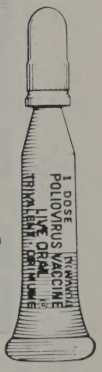

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SIDE EFFECTS of significance have not been reported. However, the risk of vaccine-induced poliomyelitis, estimated to be from 1:2,500,000 to 1:50,000,000 should be considered.

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health care industry but questionably, in comparison with other industries. This raises the question as to whether the health care service industry has to pay higher wages to attract more people from the available labor force. The flow of capital into the industry is difficult to determine since profit from investment is not the primary incentive but rather philanthropic, third party, and governmental "largesse." It is commonly held that productivity in health care has advanced less rapidly than in the economy as a whole, but this may be speculative since reliable measures of output are not available. However, some analysts do criticize the medical profession for retarding growth in productivity due to the latter's opposition to various changes proposed in the methods of organizing, producing, and financing health care services.

Having discussed some basic and general economic principles, let us discuss some currently popular solutions being proferred to alleviate this so-called problem of increasing health care costs.

PHYSICIANS

Although there has been an increase in physician fees and there is some denouncement of same, there seems to be some restraint as to any severe indictments. There is an intimation that more physicians are adjusting their fees and that these adjustments are not really of a larger percentage type. The said readjustments are based on the current economic inflationary trends, the switch from the "Robin Hood" philosophy, and the simple economic law of supply and demand. The latter factor seems by far to be playing the major influencing role. It is becoming generally accepted that the rapid increase in the demand for physicians' services is increasing faster than the supply. Moreover, there has been no related significant increase in the supply of

physicians nor does there seem to be any relief in sight for same in the immediate future. Hence, there is clamor for primary emphasis to be placed on mechanisms to increase the efficiency of existing physicians. Such increases in efficiency might be achieved through new types of organizational structures and through the use of new types of personnel who would relieve the physician of duties that individuals with less training could perform.

There seems to be an undercurrent that the solo-practicing physician is obsolete and that multispecialty comprehensive group practice is probably the best solution, particularly, if same is associated with some prepayment insurance device. Some claim that the prepayment group practice scheme would bring better care at relatively less cost to more people. Yet, cold statistics conclusively document the lack of public acceptance of and physician desire to participate in such a scheme. The fact is that fewer comprehensive group plans of either the fee-for-service or prepayment variety are being launched each year. Although some evidence does support reduced hospital utilization and increased physician productivity in prepayment group practice operations, the impersonal production line approach to this type of patient care is a compromise with quality medical care demands.

In the area of more efficient utilization of existing manpower, the concept of a highly productive health team headed by a physician employing a variety of assistants to deliver more medical care at a lower cost per unit is constantly coming to the fore. Glaring prototypes of inefficient utilization of physician manpower include such functions as eye refractions being carried on by ophthalmologists, well baby care by pediatricians, and periodic health examinations by internists. It is claimed that properly trained auxiliary medical personnel would not be a threat to a physician's status or financial position since the yardstick of success would be the improvement in the health levels of the population served by the team rather than the sacred image of the physician who is personally able to alter the course of events in a certain limited number of cases. Such a team captain, it is postulated, would not want to be paid on a "piecework" basis, but would rather expect and deserve a good salary along with time to read, study, think, plan, and maintain his own health.

HOSPITALS

Although rising wages in a tightening labor market are exerting upward pressures on hospital costs, inefficiency is certainly a key factor also. There seems to be an embarrassing lack of organization in the health care industry as witnessed by the uncoordinated re-

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lationship involving some 250,000 physicians; 7,000 hospitals; 20,000 nursing homes; 700 health insurance plans; state public health departments and welfare agencies; and innumerable voluntary health associations. Area-wide health planning with "teeth" is offered as a step in the right direction to "fill in gaps" in health services and "to avoid duplications", particularly, in highly specialized expensive, low-use services.

It is claimed that hospitals have little incentive to be efficient since the cost-plus flavor of most reimbursement schemes are not conducive to efficiency. It is suggested that reimbursement rates might be so calculated that inefficient hospitals would be under strong pressure to bring down their costs whilst efficient hospitals would find themselves with a surplus, which they could utilize to improve the scope and quality of services rendered and for capital improvements.

THIRD PARTY PAYEES

Third-party payment contributes to inefficiency by diluting the concern of the consumer, by removing him from the impact of rising costs, and by emphasizing hospitalization, particularly through service benefit plans. Health insurers are hamstringing the delivery of health services by limiting the care that a physician can prescribe. Health prepayment insurance has too long focused on payment for hospital care and has thereby invited excessive use of this type of expensive care. Physicians are tempted to use hospital care and patients demand it not because there is need for same but because insurance will pay for it. Physicians should have a wide variety of prepaid benefits at their disposal so that referrals can be made without any bias as to how benefits apply.

CONCLUSION

That health care is a right rather than a privilege and everyone is entitled to the very best of care is a wonderful political platform, but its attainment in the foreseeable future is indeed impossible. However, the push is on for reducing costs, improving supply and quality, and utilizing more efficiently available resources. Those of us in the health services' field, particularly physicians, must re-examine long established practices and search for new, better, and less expensive ways of satisfying the public's increasing demand. We, physicians, must recognize our responsibility to lead the way or someone else, probably the government, will take over.

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M.M.S. Council Meeting Highlights

A stated meeting of the Council of the MMS was held on October 11, 1967, in Boston. The following Councilors represented Hampden District: Drs. Ayres, Baker, Bloom, Burkhardt, Griffin, Hayes, Johnson, Kelly, LaMarche, Mills, Nero, Reilly, Ryan, Simpson, Susat, and Tillman. The meeting was called to order by President Donald Nickerson at 10:10 A.M. Obituaries were read but with no Hampden members included.

As a result of the action of the Fellows at the Annual Meeting of the MMS in May, 1967, there is a good deal of doubt that ex-officio members have a vote at the Council meetings. Accordingly it was voted to allow these ex-officio members to speak without special permission even though they have no vote.

MEDICAID

The Committee on Title XIX pointed out that the Law is designed to help finance medical services to all of the needy, at least to the extent that these are available to the general population. The Law prohibits any flat ceiling on income limits for eligibility, so that any individual may become eligible in a major illness regardless of income. Under the Law, the Secretary of HEW is prohibited from approving any state plan for medical assistance if he determines that approval and operation of the plan will result in a reduction of aid or assistance provided eligible individuals under a pre-existing plan. To meet this requirement, the Committee feels that "usual and customary fees" rather than a fixed fee schedule should prevail. Robert F. Ott, Commissioner of Public Welfare, in a letter to Dr. Nickerson, indicated that the Advisory Board of the Massachusetts Department of Public Welfare has voted to "continue the Blue Shield Plan B pay schedule as a basis for remuneration of Title XIX recipients for the present". He furthermore indicated that clarification of "usual and customary fees" is being sought from the Governor's Title XIX Advisory Committee, with recommendations as to what should be done on a permanent basis.

BY LAWS

The Committee on Bylaws and Council Rules presented two amendments, both of which were carried. One amendment provided for a Committee on Mental Health, while the second one provided that "the Committee on

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Mental Health shall consist of 12 fellows. It shall concern itself with matters pertaining to and treatment of mental illness and mental retardation." Additional amendments were presented to clarify the status of ex-officio councilors. It was voted to refer this entire problem of the Bylaws to an Ad Hoc Committee, to be made up of the Bylaws Committee, plus five other members of the Council, two of whom should be members of the Executive Committee.

MEMBERS' INSURANCE

A number of other committee reports were presented as informational reports requiring no Council action. Of interest among these was the report of the Committee on Members' Insurance Programs, presented by Dr. Levi. He reported that the maximum benefit on both the Blue Cross-Blue Shield Master Medical and Special Medex Certificates will be increased from $20,000.00 to $25,000.00 per insured individual as of December 1, 1967, at a small increase in premium. Dr. Levi also called the attention of the Council to the fact that coverage under Medicare is not automatic on reaching age 65 years as many believe. Because processing of Social Security forms may take as long as three months, it is recommended that physicians should enroll in the earliest of the three month period prior to reaching age 65 in order to have benefits start on time.

Attention of members approaching age 65 who are insured in the Paul Revere Life Insurance Program was also drawn to the fact that the benefit amounts and premiums are reduced on the anniversary of the date nearing this birthday. Although the term policy can be converted at any time up to age 70 without evidence of insurability to any whole-life or endowment plan then issued, it is advisable to do so prior to age 65 if the larger amounts of insurance are desired.

The Blue Shield Fee Committee gave a progress report on its efforts to revise the Blue Shield fee schedule. Meanwhile, the Committee reported that the Blue Cross-Blue Shield rate schedule will be revised as of December 1, 1967, with 14 decreases to make allowance for those individuals going on Medicare, and 6 increases in premium to cover some increases in benefits.

Under new business, a pension plan for the new secretary, Dr. Gephart, was approved. This provides for $500.00 monthly on retirement. In addition, a sickness and accident policy at a cost of $414.00 per year was approved.

The meeting adjourned at 12:30 P.M.

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IN MEMORIAM

Dr. Victor Grover of 115 Skyridge Drive, Springfield, died at The Springfield Hospital on September 27, 1967.

Born in London, England, on January 19, 1910, Dr. Grover was educated in New York City, where he graduated from Columbia University in 1931 with a B.A. degree and an M.D. degree in 1934. After interning at the Brooklyn Hospital, N. Y. from 1934 to 1936, he went on to serve a residency in internal medicine at the St. Luke's Hospital, N.Y. City, from 1936-1937. Thereupon, he served on the medical staff of the Kings County Hospital, Brooklyn, New York from 1938 to 1953 and was Director of the Medical Clinics at the Long Island College Hospital in the early 1940's. Prior to being appointed Chief of Medicine at The Springfield Hospital in 1964, Dr. Grover was associated with the Carson C. Peck Memorial Hospital, Brooklyn, New York in various capacities and was Clinical Assistant Professor of Medicine at the Downstate Medical Center College of Medicine, State University of New York, Brooklyn, N.Y.

Dr. Grover was a member of numerous medical organizations including fellowship in the American College of Physicians, of which he was recently elected third vice president, the American College of Cardiology, the American Society of Internal Medicine, and the A.M.A.; moreover, he was certified by the American Board of Internal Medicine. In New York, he was a member of many City and State medical organizations. In Massachusetts, he was a member of the Mass. Medical Society, the Hampden District Medical Society, and the Springfield Academy of Medicine.

To his family, his many friends and associates, deepest sympathy is hereby extended.

Dr. Helene (Glickman) Kasanof of 420 Sumner Ave., Springfield, died at the New England Medical Center, Boston, on October 7, 1967.

Born on June 8, 1895, in Springfield, Mass., Dr. Glickman, as she was known professionally, attended local schools and then went on to graduate from Tufts Medical School, Boston, in 1920 with a doctorate in medicine. After interning at the Woman's Hospital in Philadelphia, Pa., Dr. Glickman returned to her native Springfield and engaged in the private practice of medicine with primary concentration in the field of pediatrics.

Dr. Glickman was a member of the American Medical Association, the Mass. Medical Society, the Hampden District Medical Society, and the New England Pediatric Society.

Deepest sympathy is hereby extended to her family and to her many friends and associates.

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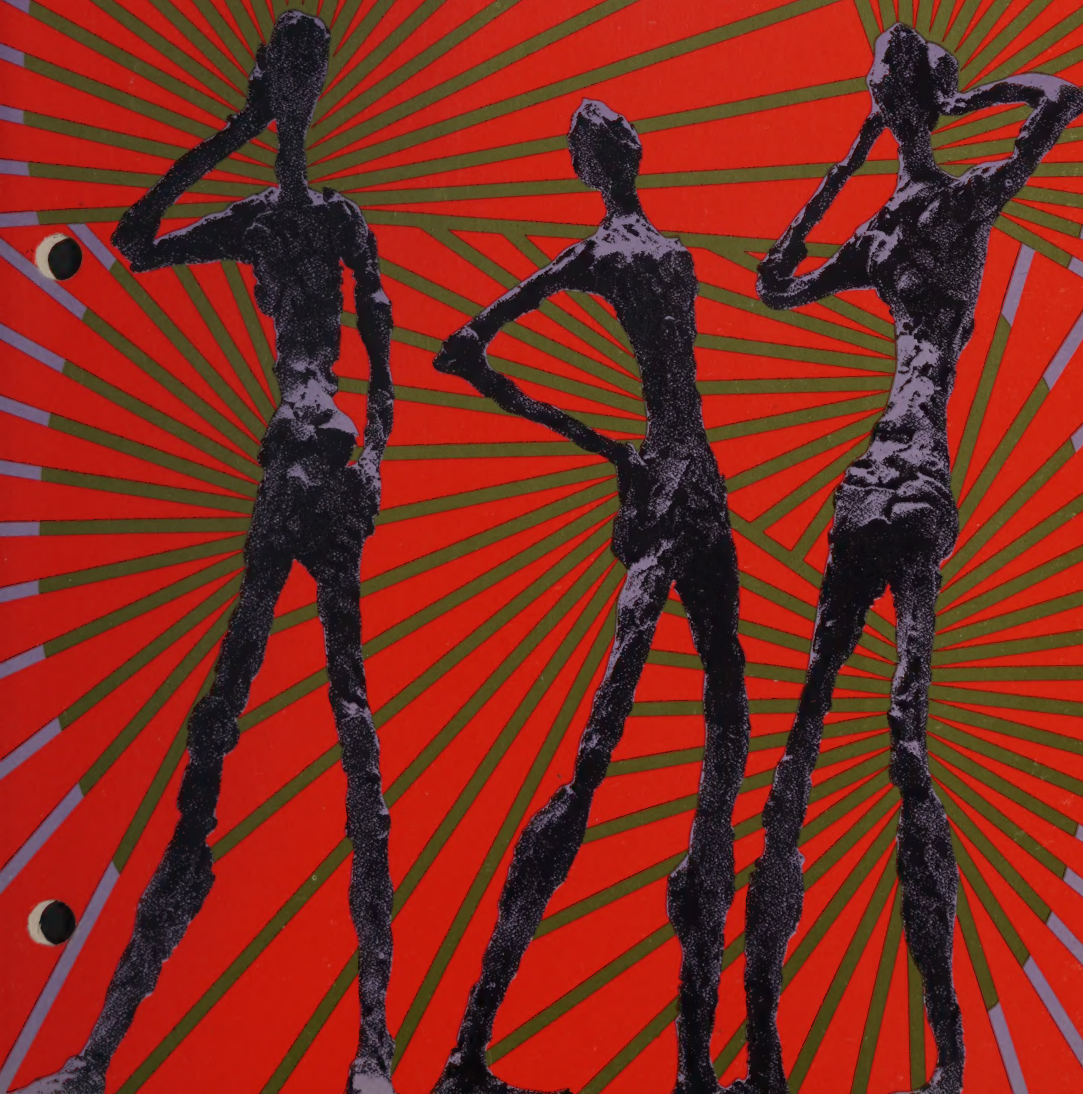

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AN EDITOR LOOKS AT PHYSICIANS AND THEIR FUTURE

By
Lewis A. Miller
Editor of "Patient Care"
Stamford, Conn.

(Excerpted from an address presented at the Springfield Academy of Medicine Meeting of May 9, 1967)

I would like to share with you some of my thinking about the problems of private practice over the next few years. Before I do, I think it's only fair that you should know something about my hidden biases in medicine.

First, I'm biased toward doctors—in their favor. I have the greatest respect for any man who is seeking to maintain his professional independence. To go a step further, I have nothing but distaste for the loud critics in government, hospitals and the lay press who continue to indulge in the childish sport of doctor-baiting. By the time I've finished reading speeches by people in HEW and the AHA, as well as the most recent copy of "Look" magazine, I'm almost brainwashed into believing that the private practitioner of medicine is guilty of all the official sins of the church, and then some. I can't swallow that kind of propaganda when I know from my own travels across the medical nation that, with singularly few exceptions, doctors are living up to the goals of their profession as well or better than any other segment of the American community.

Next, I must tell you that I'm also biased favorably toward patients, perhaps, because I am one from time to time and have gotten to see quite a few more in action, or in repose, over the years. As a believer in individual freedom, I'd like to see the patient get a little more of the same. Patients today face a bigger struggle than ever before to make any intelligent choices about medical services. True, no one is baiting the patient as they are the doctors, but no one is giving him much to go by in deciding which doctor to see for which complaint, or whether he's getting the kind of care that will do the most for his health.

PRIVATE PRACTICE TRENDS

By private practice I mean any practice controlled by one or more physicians in which payment is made either on a fee-for-service or a comprehensive prepaid basis. By the "planned medeconomy" I mean the team effort by

physicians, hospital trustees, administrators, health insurers and government to provide the best level of medical care for the most people. The term "planned medeconomy" is descriptive of the changing nature of this team effort. Providing medical care used to be pretty much a function of doctors and hospitals. Payment for care came mostly from people who could afford to pay, plus token payments from government and voluntary welfare organizations. Gradually, more organizations moved into the picture through the growth of voluntary health insurance. Labor, management and principally the health insurers themselves have taken a larger and larger role in paying for health care over the past 20 years. In most areas today, as you know, the nature of medical and hospital services and the levels of payment have been strongly influenced by these third parties. With the advent of Medicare and Title XIX, the government has become an immensely more powerful force in the "medeconomy".

REEVALUATION OF EXISTING GOVERNMENT PROGRAMS

As you know, three different approaches are embodied in the Medicare and Title XIX legislation. Part A of Medicare is financed from Social Security taxes and offers the elderly person a very specific package of first-dollar benefits for a limited time period only. Part B of Medicare is financed by voluntary contributions from subscribers matched by dollars from general tax revenues. It provides virtually unlimited benefits for medical services with some deductible features. Title XIX offers about what each state wants to offer—in some states low-fee schedule payments for a limited number of medically indigent cases; in other states, usual fees for a much greater number of eligible persons.

It stands to reason that the Department of HEW as well as members of Congress will watch the successes, failures and costs of each program very carefully over the next couple of years. At some point, it seems to make sense to revise existing legislation: (1) to set up a more uniform system for financing health care for those who need it; (2) to provide a logical pattern of benefits to fit the needs of those covered; and (3) to provide controls and restrictions so that the costs of each program can

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be accurately projected and can be justified in terms of the services rendered.

It's much too early now to tell which approach will be soundest fiscally, medically and politically. Certainly you can bet on some revisions coming along in time for debate in the Presidential election year of 1968. Some headline-hunting congressman might even propose that we dump the whole Medicare program and cover just the elderly who are medically indigent under Title XIX. When you think about the costs of Title XVIII, such a move might make fiscal sense.

GOVERNMENT PROGRAM EXPANSION

The second longer-term problem affecting the private practitioner is expansion of government health-care programs. Now that the cost figures are beginning to roll in for Medicare and Title XIX, I think legislators will go slow in adding new programs for the next few years. As you probably know, both medical and hospital costs under Medicare have been running higher than predicted.

The reevaluation I mentioned is sure to come before any major expansion. So is implementation of other health-care laws passed in 1965. These include the heart disease-cancer-stroke program, the community mental-health program and the program to improve the health of migratory workers.

But any delay in expansion of government health-care programs is purely temporary. As our economy grows, and our nation has more money to spend, our political leaders will find new ways to spend it. I'm not being critical when I say that—just realistic. Some of these new avenues of spending will surely be in the health field; in face, some proposals are already in the legislative hopper.

Senator Harrison Williams of New Jersey has proposed a network of health protection centers across the country to detect disease with a three-year price tag of $60 million. Other proposals sure to get attention in the next few years include government financed health care for children under 18, dental care for children, payment for drugs under Medicare, extended psychiatric care and extension of full Medicare benefits to the disabled and the unemployed. I would expect to see

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more Federal programs such as these in action by 1970 or 1972, hard on the heels of Medicare-Title XIX revisions.

VOLUNTARY INSURANCE EXPANSION

As Government programs expand, so will voluntary health insurance programs. In fact, the third trend affecting private practitioners will be the pell-mell race of voluntary programs to catch up with and pass the government programs.

Labor unions aren't satisfied to have their over-65 pensioners get bigger and better health benefits through Medicare than their sons get as working union members. So the push is on to bring the level of benefits at least up to those offered under Parts A and B. The most immediate effect will be that many more patients will have coverage for office medical services.

That's not all! The UAW has won at the bargaining table new coverage for short-term, outpatient psychiatric care and for convalescent or nursing-home care up to two years. Both these items are likely to be picked up in other union contracts in the next few years. In that same time, insurers expect that unions will press for and win coverage for short-term psychotherapy, dental care, vision care and prescription drugs.

How are these new coverages coming into being? Not through physicians, hospitals, or even health insurers. They're coming alive because smart union leaders are looking for unfilled needs and getting them filled at the bargaining tables with or without the support of physicians and hospitals. It seems to me that these providers of care should be counseling the negotiators instead of being handed a "fait accompli" to execute.

INCREASING CONTROLS

"He who pays the piper calls the tune." Less and less frequently, the patient pays the doctor or the hospital. The employer, the union and the government are the piper payers in our "planned medeconomy", and they represent strong, efficient organization—much stronger and more efficient than any existing organization in the health-care field.

You can expect these highly organized third parties to press for standardization in all aspects of rendering

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medical care in the office and in the hospital. For one thing, each fiscal intermediary under Medicare — the Blue plan or commercial insurance company acting on behalf of the government in each area—is now developing profiles on each physician and his practice. At the start, only flagrant abuses are being picked up, just as they have been by Blue Shield plans and other health insurance carriers. But gradually the intermediaries will have a substantial body of data on office procedures, diagnoses and fees in their areas. Similarly, the work done in each hospital will be profiled.

I can't believe that these profiles will *not* be used at some point to develop what might be called "acceptable patterns of care" in a region. Obviously it's easier to develop profiles of care in hospitals than in office practice. Yet, from the mass of statistics on office care some patterns are bound to emerge that third parties will begin to take a hard look at. In fact, the Dean of Mount Sinai Medical School in New York, Dr. George James, recently suggested that a jury of highly skilled physicians audit office care of patients covered by government programs. "It makes no sense," he said, "to audit hospital and not office care when only 10% of patient care takes place in the hospital." As you can see, the private practitioner faces some pretty rough sledding in the "planned medeconomy." In the years ahead, it'll be tougher to practice solo; it'll be tougher to practice in more than one hospital; it'll be tougher to set and adjust your own fees; and it'll be tougher to care for patients by your own standards without someone looking over your shoulder.

POSSIBLE APPROACHES

Now with those restrictions on the horizon, what can a private practitioner do to preserve his professional integrity? How can he set up the kind of practice he wants within the framework of the "planned medeconomy"? I'd like to make some suggestions that might stimulate your thinking.

Each of you, I believe, has an opportunity that may not last forever—an opportunity to build in the medical staff of your community hospital an organization that can help private practice survive in the "planned medeconomy." It won't be easy to build such an or-

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ganization; the traditional autonomies in medical practice die hard. But die they must, if you are to stand up to the pressures of government, labor, industry, and health insurers. For several years, I've been mouthing the same words that hundreds of others have: "The physician must be captain of the health-care team." Well, I don't think he'll be captain! In fact, he may not even make the team unless he plays the game the way the other players do, namely, by the rules of organization.

What changes are necessary to play by the rules of organization? The paramount requirement is to build an effective national medical organization on a foundation of small, homogeneous units—the medical staffs in community hospitals. This kind of grass roots organization contributed to the strength of the Christian Church and the AFL-CIO, to name just two members of the power structure in today's society. It can give substantial new strength to the anemic body politic of the A.M.A. and its constituent state and county societies.

So, I come back to you and your opportunity to strengthen your medical staffs. I make my suggestions with the knowledge that they can't be imposed, but must be sold to each medical staff. With that "caveat", I'll offer these six steps to an organized staff:

1. Encourage most "attendings" (sub-specialists excepted) to limit their work to one hospital. The time is rapidly passing when a man can spread himself among two or more hospitals and still play an effective role in organized patient care.

2. Try to develop among the members of the medical staff a real awareness of the costs of short-term hospital care, compared with the costs of extended care, home care and office care. Like it or not, the economic factor has to be part of the judgmental process in rendering good quality care, and doctors ought to make the judgments, not third parties. Try to make the medical staff aware as well of the help that patients can get at low cost through social workers and community agencies. Many doctors I know are too busy to keep up with what's available in paramedical services.

3. Emphasive the need to develop adequate written standards of hospital care by diagnosis. These standards might cover such items as minimum

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laboratory and diagnostic tests, consultation, length of stay, etc. Such a voluntary effort to set standards could undercut the inevitable pressure from third parties to adhere to their computer print-outs.

4. Encourage "attendings" to make their hospital charts a part of their office medical records on all patients and vice-versa. I look on this as the first step toward developing a uniform system of medical records in office and hospital so that information on patients is readily transferable to the point of use. There's no more sense in a patient having one record in the office and another in the hospital than there is in a married couple having separate bedrooms. It's a sign that somebody "goofed!"

5. Work toward a centralized bookkeeping and billing system for all members of the medical staff, leaving each physician the right to set his own fees but freeing him from the increasingly complicated paper work of third-party payments. In many cases, the hospital computer should be able to add the accounting work for its medical staff to its own at modest cost.

6. Try to develop the medical staff into a cohesive group of physicians—not a group practice in the usual sense—but a group in terms of coverage, consultation, uniform medical records, uniform financial records, and even a common location in medical offices in or near the hospital. Such a group offers each physician on the medical staff the freedom to work at his own pace, set his own fees, and maintain his personal physician-patient relationships. At the same time, it offers him a strong local organization dedicated to a high standard of cost-conscious care.

Through this kind of grass-roots organization, private practitioners can build the strength they will need to work effectively with third parties and not be worked over by them.

These suggestions are necessarily sketchy for they're meant to point a direction and not to spell out a definitive program. My purpose is to stimulate you to respond to the need for a vital new kind of organization in medicine—a strong grass-roots organization that will enable private practice to survive in the "planned medeconomy."

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Seminars on Psychiatry

The Committee on Psychiatric Education of the Western Massachusetts Psychiatric Society, in cooperation with representatives of the local District Medical Societies and Chapters of the American Academy of General Practice, has arranged a series of eight Seminars on Psychiatry for the Practicing Physician to be held during the Fall of 1967 and Spring of 1968.

This year the program for GP Postgraduate Education in Psychiatry is being supported by a grant from the National Institute of Mental Health to Jack R. Ewalt, M.D., Executive Director, Massachusetts Mental Health Research Corporation, with B. G. Morrison, M.D., Acting Chief of Staff, VA Hospital, Northampton, Massachusetts, as the Program Director.

Each Seminar will begin with a lecture-demonstration given by an invited speaker. The participants will then be assigned to one of four discussion groups, with a local psychiatrist serving as the group leader. The groups will then reassemble for a summation of the subject, with the group leaders forming a panel and the invited speaker serving as moderator.

Each Seminar will be held in the Staff Room of the VA Hospital, Northampton, Massachusetts, from 7:00 p.m. to 9:30 p.m. on the dates designated.

All physicians are cordially invited to attend one or more of these Seminars.

There is no registration fee for any of the Seminars.

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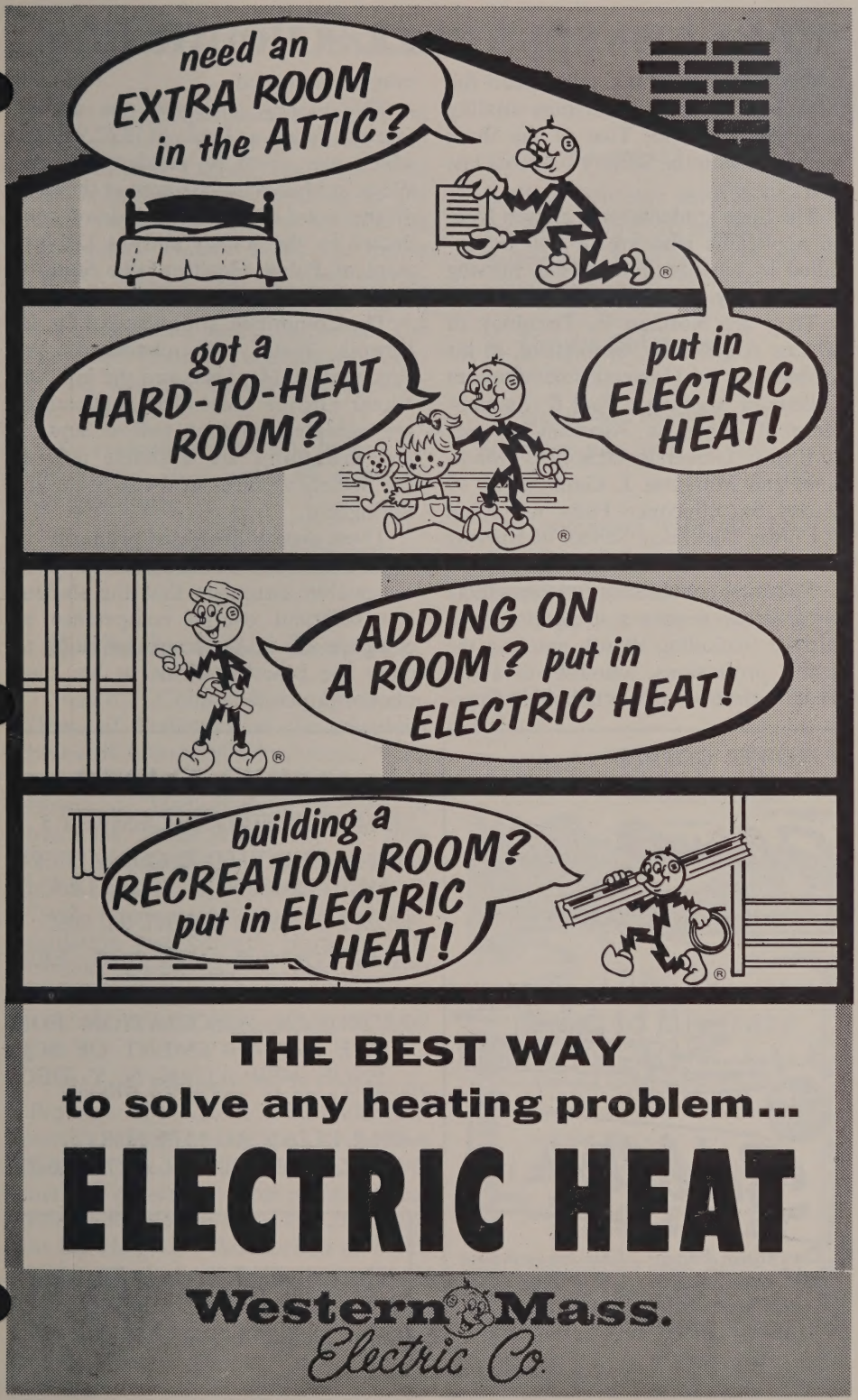
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HDMS AWARDS THREE SCHOLARSHIPS

The HDMS recently announced the awarding of three scholarships totaling more than $1,000. Two of the three recipients won the Society's awards last year.

The three students were chosen from 26 applicants who are or will be enrolled in schools of medicine, nursing or pharmacy.

They are Norman F. Tremblay of 30 Los Angeles St., Springfield, in his second year at University of Vermont College of Medicine; Paul C. Salmonsen of 50 Albert St., Agawam, a junior at Baylor University School of Medicine; and Margaret J. Gauthier of 19 Muzzy St., Chicopee Falls, a student at Cooley Dickinson School of Nursing in Northampton.

The total scholarship fund available for grants to residents of the Hampden District (including Ware), entering the health professions, amounts to about $1,067, the Society's Scholarship Committee announced.

This money represents the annual interest from a fund of $22,969.01 which was given by residents of this Western Massachusetts area at the time of the polio immunization drive conducted by the Society and the Department of Public Health of the State of Massachusetts.

The Committee, comprised of Dr. B. Lincoln Wales, Jr., chairman, Dr. Frederick S. Hopkins, and the late Dr. Victor Grover notes that applications are accepted anytime before Sept. 1 and that forms are available now at the Society's offices at 1414 State St., Springfield.

These awards are based primarily on financial need in conjunction with reasonable assurance that the student has sufficient overall competence to complete his or her course of study to enter the practice of his or her own chosen profession.

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HDMS MEETING, DECEMBER 5

HDMS EXECUTIVE COMMITTEE MEETINGS, NOV. 21 and DEC 19

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MMS COUNCIL MEETING, FEB. 7, 1968

AMERICAN ASSOCIATION FOR THE ADVANCEMENT OF SCIENCE, NEW YORK, N. Y. DEC. 26-31

AMA CLINICAL MEETING HOUSTON, TEXAS., NOV. 26-29

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THE HAZARDS OF SMOKING

The HDMS sponsored a program on the Hazards of Smoking recently with Drs. Howard Turner, Frederick Post and John Griffin participating in the panel discussion. This was held during Community Health Week. A movie "WHO, ME?", lent by the Massachusetts Heart Association, was shown to a group of 76 interested people. The Hampden County Tuberculosis Association and the Cancer Society were also represented.

An evaluation sheet was passed out and of the 76 present, 46 answered the questions.

	Yes	No
1. Do you smoke?	34	12
2. Have you ever smoked? (of the 12 no's, 10 smoked before and 2 never).		
3. Did you enjoy the film?	43	1
4. Did you find the panel interesting?	45	
5. Would you be interested in more programs of this type?	40	1

The comments were all favorable and suggested that more of this type program be presented particularly to junior high and high school students.

Pediatric Guest Lectures

Platon J. Collipp, M.D., Chairman, Dept. of Pediatrics at the Meadowbrook Hospital, Meadowbrook, N.Y., and Clinical Associate Professor at the Downstate Medical Center College of Medicine, State University of New York, in Brooklyn will be the pediatric guest speaker on Thursday, Dec. 7, 1967. His topic will be "Growth Retardation and Growth Hormone". A clinical session will be held at 5:00 p.m.; pediatric rounds, at 6:00 p.m.; and the formal presentation at 8:00 p.m.

Thomas Twitchell, M.D., Associate Professor of Medicine at the Tufts University School of Medicine and the New England Medical Center, Boston, will make a presentation on pediatric neurology on Wednesday, Dec. 20, 1967, in the Hospital's Auditorium at 10:00 a.m. as part of the Postgraduate Medical Institute Guest Lecture Series.

All physicians, residents, interns, nurses, and military personnel are cordially invited to attend.

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ACADEMY

The next meeting of the
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will be held on
TUESDAY, DECEMBER 12, at 8:30 P.M.

SPEAKER: RICHARD W. WILSON, M.D.
Director, Tumor Clinic
Peter Bent Brigham Hospital
Boston, Massachusetts

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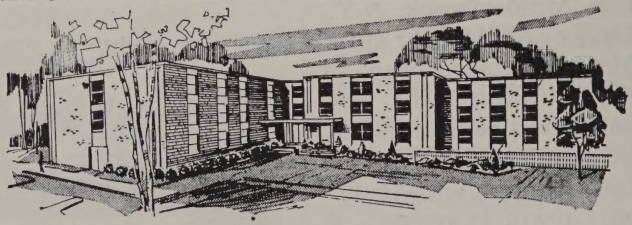

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RADIO

HDMS has been invited by Radio WACE—730 on your dial every other Friday at 1:00-2:00 p.m.—to participate again in the hour long program, "FOR YOUR INFORMATION". The first broadcast in this series was presented on November 10, when Dr. Izenstein spoke about DIABETES DETECTION WEEK which is from November 11-17. If you care to be on the air with Bill MacIver on WACE, please contact Mrs. Purdy at the HDMS office.

Needed: volunteers to record short health tips at WSPR—stop in any time and ask for Bud Clain at 63 Chestnut Street, Springfield, Mass.

NEWSPAPER SERIES

Keep watch in the Springfield Daily News for a new series of articles on the page for medical affairs. HDMS will be participating in questions and answers planned by your Public Relations Committee.

PERSONALS

Dr. Ira Chamberlin has retired, after 46 years of practice, to 6 Pine Valley Circle, Ormond Beach, Florida.

Dr. Paul G. Sanderson has moved from Kimball Towers to Georgetown Apartments.

Dr. Karel J. Susat was elected fellow in the American College of Surgeons.

Mrs. Carroll Bryant was recipient of "ORCHIDS TO YOU" from the Springfield Daily News.

Dr. and Mrs. O'Malley of Holyoke celebrated their 25th wedding anniversary recently.

Dr. Alifano was recently honored by the President of Italy for his outstanding achievements in the literary field.

TRANSFERS

Dr. Alan Gerstein from non-resident member of MMS to Hampden.

Dr. Alan Janes from Berkshire District to Hampden.

Dr. Carl F. Brandfass, Jr., from Hampshire to Hampden.

SPEAKERS

Dr. Bloniarz spoke to Springfield Chapter of National Secretaries Association on "RISK REDUCTION".

Dr. Walter Tauber spoke at Washington School PTA.

Dr. Hill spoke to East Longmeadow Lions Club.

Dr. Keitlen spoke to school in Chicopee on "Sex Education".

Dr. Zadworny spoke to Division of Employment Security with "QUARTER MILLION TEENAGERS".

The HDMS movie "Quarter Million Teenagers" was lent to Mercy Hospital School of Nursing for viewing. Any hospitals wishing to borrow this movie are welcome to do so.

COMMITTEE MEETINGS

The following committees held meetings during October Mental Health, Public Health, Public Relations and Executive. Are you a committee chairman? Have you planned a meeting? If not, better call 736-0661 and plan one.

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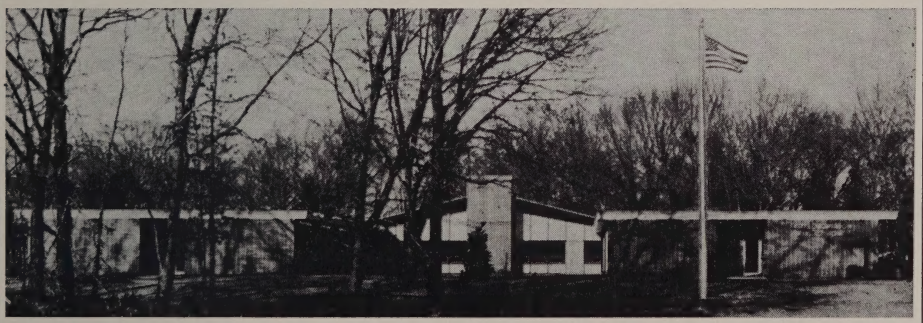

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